JON F. GRAHAM, M.D.
1329 Lusitana Street – Suite 301
Honolulu, Hawaii 96813
(808) 560-4939 / Fax (808) 538-8437

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REQUEST FOR AUTHORIZATION

To: James Matson
RSKCO
Fax: 522-2255

Date: 01/16/01

From: Dr. Graham/ Sandi

Patient: Daniel Backman

Address: 94-872 Lumiholoi Street
Waipahu, Hawaii 96797

Date of Injury / Hospital Admit.

☒ Male ☐ Female DOB: 01-06-5

Telephone: 678-1798

Insurance: ☐ HMSA ☐ Medicare ☐ Medicaid ☐ HMAA ☐ UHA ☐ Other

☐ Auto ☒ W/C

Policy/Group No.: Insured's name (if other than patient):

Diagnosis: 1. 722.0 - C5 Radiculopathy 2.

3. 4.

Reason for Request / Authorization: Surgical Procedure - C4-5 microforaminotomy
CPT: 63081 and 69990

Date of Scheduled Appointment / Procedure: Pending Approval Time:

Comments: PLEASE INFORM US ASAP REGARDING STATUS OF REQUEST. Thank you!

☐ APPROVED
Authorization No.:

☐ DENIED
Reason:

by:
Signature: Date:

Print name: Telephone:

B 0894

EXHIBIT 11